DAY SURGERY PRE-ADMISSION ASSESSMENT

DOMESTIC VIOLENCE/ABUSE

Do you feel unsafe or afraid of anyone (e.g. your partner, a relative, or anyone else)? ☐ Yes ☑ No If yes, who? _____
Is anyone trying to control you (e.g. where you go, who you talk to, what you wear, how you spend money)? ☐ Yes ☐ No If yes, who? _____
Has anyone hurt you, threatened to hurt you or someone that you care about? (For example, has anyone hit, slapped, or kicked you or forced you to perform sexual acts against your will)? ☐ Yes ☐ No If yes, who? _____

FALL RISK

Circle appropriate score. Choose one score per item number.

1. History of Falling	yes = 25	no = 0	5. Gait		
2. Secondary Diagnosis	yes = 15	no = 0	A. Normal/bedrest/wheelchair	yes = 0	
3. Ambulatory Aid			B. Weak	yes = 10	
A. None/bedrest/nurse assist	yes = 0		C. Impaired	yes = 20	
B. Crutches/cane/walker	yes = 15		6. Mental Status		
C. Furniture	yes = 30		A. Oriented to own ability	yes = 0	
4. IV Therapy/Heparin Lock	yes = 20	no = 0	B. Overestimates/forgets limitations	yes = 15	

FALL TOTAL (1-6): 0

Risk for Physiological Fall: ~~NO RISK = 0~~ LOW RISK = 1-24 MODERATE RISK = 25-45 HIGH RISK = >45

** If RISK SCORE is 36 or more put an ORANGE armband on patient **

Mobility: ☑ Ambulate ☐ Cane ☐ Crutches ☐ Walker ☐ Wheelchair
Difficulty with ADL ☐ Yes ☐ No Recent Falls ☐ Yes ☑ No Swallowing Problem ☐ Yes ☑ No
Appetite changes ☐ Yes ☑ No Weight Loss greater than 10 lbs. in last 3 months ☐ Yes ☐ No
If yes to functional or nutritional assessment, patient advised to see PCP for evaluation and treatment ☐ Yes

PAIN ASSESSMENT

Level of consciousness: alert and oriented ✓
easily aroused _____
difficult to arouse _____
somnolent _____

Do you have pain now? ☐ Yes ☐ No
Pain location _____
Have you had this pain before? ☐ Yes ☐ No
Pain intensity: # _____ Scale used: Verbal Numeric (0-10) _____
FLACC (0-10) _____
Facial Numeric (0-10) _____
Infant (0-10) _____
Pain Onset/Duration: _____
Pain Quality: Sharp _____ Dull _____ Stabbing _____ Pressure _____ Throbbing _____ Burning _____
and/or in patient s own words: _____
Pain Patterns: Intermittent _____ Constant _____ Both _____
Aggravating Factors: _____
Relieving Factors: _____
Current Pain Management: _____
Patient s Pain Goal (0-10) _____

Educational Goals Met; patient informed:
_____ Pain management is an important part of your treatment.
_____ Your opinion about how to manage your pain is important.
_____ You can expect a timely response to reports of pain.
_____ Pain information booklet was given.

Patient advised to see PCP for evaluation and treatment of pain ☐ Yes ☐ No ☐ Not Applicable

Comments: _____

_____ RN _____ Date

Do you have any other pain? ☐ Yes ☑ No
Describe (if yes): If yes, proceed to Secondary Pain Assessment form.

PREOPERATIVE CHECKLIST

O_2 SAT.	RESP RATE	RHYTHM	DESCRIBED-BREATH SOUNDS	PULSE	RHYTHM	BP	TEMPERATURE

Patient has Pacemaker ❑ AICD ❑
PATIENT'S UNDERSTANDING OF PROCEDURE Right knee arthroscopy

ALLERGIES: NKDA

Height: 6'1" Weight: 260# 117.9

Nothing by mouth since: ❑ AM ❑ PM

LAST VOID: ❑ AM ❑ PM

Latex Allergy: ❑ Yes ❑ No If yes, OR notified ❑

LEVEL OF CONSCIOUSNESS: ❑ Alert ❑ Oriented ❑ Disoriented | Attention Span

Present Behavior: ❑ Talkative ❑ Lethargic ❑ Cooperative ❑ Anxious ❑ Combative ❑ Depressed ❑ Unresponsive ❑ Other _____

Mobility: ❑ Ambulate ❑ Cane ❑ Crutches ❑ Walker ❑ Wheelchair | Body Posture

PATIENT SIGNED CONSENT	❑ Yes	❑ No	HAIRPINS, MAKE-UP AND NAIL POLISH REMOVED	❑ Yes	❑ No	❑ N/A
PHYSICIAN SIGNED CONSENT	❑ Yes	❑ No	PROSTHESIS REMOVED	❑ Yes	❑ No	❑ N/A
ID BAND ON PATIENT	❑ Yes	❑ No	HEARING AID REMOVED	❑ Yes	❑ No	❑ N/A
VALUABLES, JEWELRY REMOVED	❑ Yes	❑ No	EYE GLASSES / CONTACT LENSES REMOVED	❑ Yes	❑ No	❑ N/A
TATTOOS	❑ Yes	❑ No	DENTURES REMOVED partial: crowns	❑ Yes	❑ No	❑ N/A
			BODY JEWELRY REMOVED	❑ Yes	❑ No	❑ N/A

NAME, TELEPHONE NUMBER AND LOCATION OF PERSON TO CONTACT AFTER SURGERY
NAME Janice Rollins, fiancé
LOCATION TELEPHONE #

NURSING OBSERVATIONS

Admission Date: Time:	Discharge plan:
Preop checklist completed: ❑ Yes	❑ Home with responsible adult, written instructions
Patient verbalizes understanding of preop and postop	and follow-up with MD.
instructions ❑ Yes ❑ If No, explain:	
Patient assisted to anesthesia holding area, placed on	
- stretcher ❑	
- recliner ❑	
	RN

HEALTH CARE PROXY ❑ Yes ❑ No If yes, Health Care Proxy Agent: _____ (Name) _____ (Phone)
COPY IN CHART ❑ Yes ❑ No

Pre-Admission Assessment reviewed Yes ❑ Revised Day of Surgery ❑ Yes ❑ Not Applicable

NURSING DIAGNOSIS	EXPECTED OUTCOME	INTERVENTIONS	SIGNATURES	INITIALS
1. Knowledge deficit re: perioperative process.	Patient will ask pertinent questions and verbalize understanding of what is expected in the perioperative period.	Inform about preop and postop procedures and restrictions. Review preop and postop instructions.		
2. Anxiety, fear of the unknown.	The patient expresses feeling of comfort and lessened anxiety prior to anesthetic induction.	Assess level of anxiety and possible causes, taking appropriate action.		

FAULKNER HOSPITAL

Brigham and Women's Health Care

PATIENT IDENTIFICATION AREA

CENTER FOR PREOPERATIVE EVALUATION

PREOPERATIVE INSTRUCTIONS

Your surgery has been scheduled for: Date _____

On the last business day before your surgery please contact the Day Surgery Unit at (617) 983-7179 to confirm your time of arrival. The best time to call is between 10 am - 1 pm.

Upon your arrival at the hospital, report to the Day Surgery Preop area on the first floor. (If you are to be admitted to the hospital following your surgery, report to Central Registration/Admitting.)

TO BE PREPARED FOR YOUR SURGERY, PLEASE READ AND FOLLOW ALL THESE INSTRUCTIONS.

Section A - Medications

- On the morning of surgery please take the following medication, with a small sip of water: _____
- Do not take aspirin for 7 days before your procedure. If aspirin or Plavix is prescribed for your heart, please check with your Primary Physician or Cardiologist before stopping this.
- Do not take anti-inflammatory medicines such as Relafen, Motrin Advil, Ibuprofen, Naprosyn, Lodine, Day Pro, or Oruvail *for 48 hours before your procedure.* ***Tylenol is acceptable.***
- If you are on blood-thinning medicine such as Coumadin, Plavix, Heparin, Lovenox, Persantine, Ticlid or Trental, please notify the nurse in Preoperative Evaluation.
- Do not take Vitamin E or any herbal supplements for one week before surgery.
- If you are a diabetic, do not take insulin or diabetic pills the morning of your procedure. Please bring them with you.
- Bring your asthma inhalers with you to the hospital.
- Stop smoking. This is important for your health and recovery.
- *Limit alcohol prior to surgery and avoid alcohol the day before surgery.*

Section B - General Instructions

- Do not wear make-up the day of surgery.
- Do not bring valuables with you to the hospital, including money, credit cards, jewelry, cell phones, etc.
- Remove nail polish, contact lenses and all jewelry (including body piercings).
- Nothing to eat or drink after midnight on the evening before surgery. This includes water.
- Do not chew gum or have any mints or hard candy the morning of surgery.
- You may brush your teeth the morning of surgery.
- Special instructions for children: _____
- Do not use any hair products after shampooing, such as conditioners, gels, hairspray, etc. on the day of surgery.
- Do not use body lotions, sprays or moisturizers on the day of surgery.

Section C - Day Surgery

- Please make arrangements for someone to drive you home after surgery. You will not be allowed to drive yourself home.
- You may not go home in a taxi by yourself.
- For your safety, please make arrangements for someone to stay with you the night of surgery.
- Review the copy of home care instructions provided.
- Visitors are allowed in the Recovery Room when patients are preparing to go home.

Person responsible for your ride home: _____

Phone #: _____

If you feel ill or have questions prior to your surgery, call the Preadmission Screening Unit and ask to speak with a nurse.

Center for Preoperative Evaluation at Faulkner Hospital: Hours 7:30AM to 4:30PM, Monday to Friday, (617) 983-7179 or (617) 983-7419 voice mail, FAX # (617) 983-7723

Phone number where you can be reached, if the staff needs to contact you: _____

_____ _____

Date *Patient or Significant Other*

_____ R.N.

67165 7/07 WHITE - Patient Copy YELLOW - Medical Record

Faulkner Hospital

ANESTHESIA CONSENT FORM

Patient Identification

Dr. _____ has explained to me that a member or members of the Department of Anesthesia will induce anesthesia for relief of pain during the procedure(s) set forth on the Procedure Consent Form.

I understand that anesthesia involves a potential for risks including, and in addition to, those described on the Procedure Consent form. These risks may include such things as injury to teeth, allergic reaction, damage to vocal cords, cardiac and / or respiratory problems, pain and discomfort, headaches, and loss of sensation or life.

I acknowledge that I have discussed the use of anesthesia or conscious sedation with a member of the Department of Anesthesia, who has explained the risks of the use of anesthesia or conscious sedation. All of my questions have been answered to my satisfaction.

I understand that due to the reversible nature of perioperative events and the intrinsic life support character of anesthesia, Do-Not-Resuscitate (DNR) status can be suspended during the performance of invasive procedures requiring anesthesia or conscious sedation. The DNR orders are then reinstituted after performance of the procedure and discharge from Post Anesthesia Care. I may, after consultation with my physician, request specific limitations to treatments as noted below.

_____

_____

After discussion, if there are no specific limitations to treatment, I give consent to suspend "Do-Not-Resuscitate" orders during the surgery and post anesthesia care.

I give my consent to the induction of anesthesia.

_____ _____

Patient's Signature Date

_____ _____

Anesthesiologist's Signature Date

FAULKNER HOSPITAL

Brigham and Women's Health Care

DATE	RM/BED	SERV AREA	MS	RELIGION
09/11/08		SURGICAL D	D	P

PATIENT

Unit# 01018512 Acct# 23601656
ROLLINS,JAMES
8 SHABAZZ WAY

BOSTON MA 02119
(617)999-0577

DOB: 08/12/56 AGE: 52 SEX: M

DIAGNOSIS

ATTENDING MD
BLEY,LOUIS M.D.

MD PHONE
(617)629-6242

EMPLOYER

NOT EMPLOYED

NEXT OF KIN

ROLLINS,JAMES

OSTERVILLE MA
(508)428-9943
FATHER

PERSON TO NOTIFY

ROLLINS,JAMES

OSTERVILLE MA
(508)428-9943

GUARANTOR

ROLLINS,JAMES
8 SHABAZZ WAY

BOSTON MA 02119
(617)999-0577

GUARANTOR EMPLOYER

NOT EMPLOYED

INSURANCE

HARVARD PILGRIM HEALTHCA
HP113408001
ROLLINS,JAMES
SAME AS PATIENT

PCP: DIAMOND,ERIC M.D.
GRP: HVMA - POST OFFICE SQUARE

Primary Language spoken at home:

English

Last Inpatient Visit Date: 04/05/08

Receipt of Privacy Notice: SIGNED
Date of Receipt: 04/06/2008

DUBMAR

BRIEF OPERATIVE NOTE (Dictated Note Required):

PREOPERATIVE DIAGNOSIS:

POSTOPERATIVE DIAGNOSIS:

PROCEDURE:

SURGEON:

ASSISTANT:

FINDINGS:

ANESTHESIA:

FLUIDS:

URINE OUTPUT:

ESTIMATED BLOOD LOSS:

SPECIMEN:

DICTATED BY ATTENDING: ☐

RESIDENT: ☐

DICTATION JOB NUMBER _____

SIGNATURE: DATE/TIME:

POST PROCEDURE NOTE

SIGNATURE: DATE/TIME:

DISCHARGE INFORMATION *(Dictated Discharge Summary required if stay is greater than 48 hours)*

DISCHARGE DATE

DISCHARGE DIAGNOSIS

CONDITION AT DISCHARGE

DISCHARGE MEDICATION

FOLLOWUP APPOINTMENT

PHYSICIAN	PHONE	DATE/TIME

SIGNATURE M.D. DATE/TIME

FAULKNER HOSPITAL

Brigham and Women's Health Care

23601656 01018512

ROLLINS, JAMES
02/12/1956 BLEY, LOUIS M.D.
8 SHABAZZ WAY BOSTON
09/11/2008

PATIENT IDENTIFICATION AREA

CENTER FOR PREOPERATIVE EVALUATION

PREOPERATIVE INSTRUCTIONS

Your surgery has been scheduled for: Date 9/4/08

On the last business day before your surgery please contact the Day Surgery Unit at (617) 983-7179 to confirm your time of arrival. The best time to call is between 1 pm - 3 pm. Call 9/3

Upon your arrival at the hospital, report to the Day Surgery Preop area on the first floor. (If you are to be admitted to the hospital following your surgery, report to Central Registration/Admitting.)

TO BE PREPARED FOR YOUR SURGERY, PLEASE READ AND FOLLOW ALL THESE INSTRUCTIONS.

Section A - Medications

- On the morning of surgery please take the following medication, with a small sip of water: Metoprolol Coumadin
- Do not take aspirin for 7 days before your procedure. If aspirin or Plavix is prescribed for your heart, please check with your Primary Physician or Cardiologist before stopping this.
- Do not take anti-inflammatory medicines such as Relafen, Motrin Advil, Ibuprofen, Naprosyn, Lodine, Day Pro, or Oruvail for 48 hours before your procedure. **Tylenol is acceptable.**
- If you are on blood-thinning medicine such as Coumadin, Plavix, Heparin, Lovenox, Persantine, Ticlid or Trental, please notify the nurse in Preoperative Evaluation.
- Do not take Vitamin E or any herbal supplements for one week before surgery.
- If you are a diabetic, do not take insulin or diabetic pills the morning of your procedure.
- Bring your asthma inhalers with you to the hospital.
- Stop smoking. This is important for your health and recovery.
- Limit alcohol prior to surgery and avoid alcohol the day before surgery.

Section B - General Instructions

- Do not wear make-up the day of surgery.
- Do not bring valuables with you to the hospital, including money, credit cards, jewelry, cell phones, etc.
- Remove nail polish, contact lenses and all jewelry (including body piercings).
- Nothing to eat or drink after midnight on the evening before surgery. This includes water.
- Do not chew gum or have any mints or hard candy the morning of surgery.
- You may brush your teeth the morning of surgery.
- Special instructions for children: _____
- Do not use any hair products after shampooing, such as conditioners, gels, hairspray, etc. on the day of surgery.
- Do not use body lotions, sprays or moisturizers on the day of surgery.

Section C - Day Surgery

- Please make arrangements for someone to drive you home after surgery. You will not be allowed to drive yourself home.
- You may not go home in a taxi by yourself.
- For your safety, please make arrangements for someone to stay with you the night of surgery.
- Review the copy of home care instructions provided.
- Visitors are allowed in the Recovery Room when patients are preparing to go home.

If you feel ill or have questions prior to your surgery, call the Preadmission Screening Unit and ask to speak with a nurse.
Person responsible for your ride home: _____

Phone #**Center for Preoperative Evaluation at Faulkner Hospital: Hours 7:30AM to 4:30PM, Monday to Friday, (617) 983-7179 or (617) 983-7419 voice mail, FAX # (617) 983-7723**

Phone number where you can be reached, if the staff needs to contact you: _____

9/28/08 Phone

Date

Patient or Significant Other

R.N.

FAULKNER HOSPITAL

Brigham and Women's Health Care

SURGICAL DAY CARE
HOME CARE INSTRUCTIONS
KNEE ARTHROSCOPIC SURGERY

23601656 01018512

POLLINS,JAMES
08/12/1956 BLEY,LOUIS M.D.
8 SHABAZZ WAY BOSTON
09/11/2008

Date

PATIENT IDENTIFICATION AREA

Diagnosis

Procedure

Medications

Physician

Physician Tel #

Next Office Appointment

INSTRUCTIONS

1) Keep ice on your knee for the first 72 hours.
2) Lie down with your leg elevated higher than the level of your heart.
3) Use only partial/full weight bearing with crutches. (See crutch walking sheet.)
4) Begin quadriceps exercises in 48-72 hours. _____
5) Keep knee clean and dry. Change dressing in 48 hours. Use ace wrap if needed for support.
6) Check the circulation of your foot and toes frequently. Call your physician if:
   a) your toes and/or foot become pale, cool, and feel numb.
   b) there is severe redness or swelling of your operative site.
   c) severe pain, unrelieved by pain medication.
   d) unusual discharge from your wound.
   e) temperature greater than 100.5° F.
   f) difficulty urinating.
7) Due to urinate by 10pm
8) You may shower after 48 hours.
9) Call office for a 10-14 day follow-up appointment.
10) Additional instructions: _____

POST-ANESTHESIA INSTRUCTIONS

1) You should not drive an automobile yourself and must be accompanied home by a responsible adult.
2) Remain at home for 24 hours.
3) Refrain from activities in which decreased alertness might be a hazard for 24 hours:
   a) Do not drive a car.
   b) Do not make crucial decisions.
   c) Do not work complicated machines.
4) Do not drink alcoholic beverages for 24 hours after anesthesia.
5) If you have any problems associated with your surgery and/or anesthesia, call your physician immediately.
6) No smoking without supervision for 24 hours.

If you experience new onset chest pain or shortness of breath, go to the nearest emergency room for evaluation.

Signature: _____
Patient

_____
Nurse Discharging Patient

_____
Responsible Adult

FAULKNER HOSPITAL

Brigham and Women's Health Care

SURGICAL DAY CARE
HOME CARE GUIDELINES
CRUTCH WALKING

23601656 01018512
ROLLINS, JAMES
08/12/1956 BLEY, LOUIS M.D.
8 SHABAZZ WAY BOSTON
09/11/2008

Date

PATIENT IDENTIFICATION AREA

Diagnosis

Procedure

Medications

Physician

Next Office Appointment

Physician Tel #

CRUTCH FITTING INSTRUCTIONS:

- Two finger space between armpit and axillary pad
- Fifteen degree bend at the elbow

TYPES OF WEIGHT BEARING PRECAUTIONS:

A. **NON-WEIGHT BEARING:** Do not apply any weight through involved leg.
B. **TOUCH DOWN WEIGHT BEARING:** Allow only the ball of the foot to touch the floor for balance purposes.
C. **PARTIAL WEIGHT BEARING:** Allow a maximum of 50% body weight to be applied to the involved leg.
D. **WEIGHT BEARING AS TOLERATED:** Allow as much weight as tolerated through the involved leg.

USE OF CRUTCHES:

ON LEVEL SURFACES

- Crutch tips should be approximately 6" in front and 6" to the side of both legs.
- Advance both crutches, then the involved leg followed by the uninvolved leg.
- Continue this sequence applying proper weight bearing precautions.

ON STAIRS (with railing)

Upstairs:

- Hold the rail with one hand while the opposite hand holds the crutches.
- Step upward with the uninvolved leg followed by the crutches and the involved leg.

Downstairs:

- Hold the rail while placing the crutch on the lower step.
- Place the involved leg on the step to meet the crutch followed by the uninvolved leg.

ON STAIRS (*without use of railing*)

Upstairs:

- Step upward with uninvolved leg
- Follow with crutches and involved leg

Downstairs:

- *Place crutches on lower step followed by the involved leg.*
- Follow with uninvolved leg.

→ ***BE SURE TO APPLY WEIGHT BEARING PRECAUTIONS APPROPRIATELY DURING USE OF THE STAIRS JUST AS ON LEVEL SURFACES***

TIPS AND SAFETY:

- When using crutches, be sure to place weight through hands, not armpits.
- Squeeze crutches between your arms and chest wall if a rest is needed during standing.
- If light-headed/dizziness occurs, avoid use of crutches or if in the process of walking, call for help.
- Be aware of the walking surface (i.e. indoors/outdoors).
- Remove scatter rugs from areas to be walked upon.

If you experience new onset chest pain or shortness of breath, go to the nearest emergency room for evaluation.

Signature:

Patient

Nurse Discharging Patient

Responsible Adult

CHECK WITH YOUR DOCTOR ABOUT WHICH EXERCISES THEY WOULD LIKE YOU TO PERFORM.

GENERAL INSTRUCTIONS FOR POSTOPERATIVE KNEE SURGERY

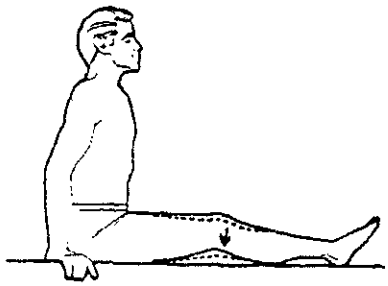
Success of your rehab is directly related to your commitment to an exercise program. Consistent exercise produces results. With exercise some muscle soreness or stretching may be felt. This is normal.

Follow the exercise routine outlined by your physician and or Physical therapist. Gradually increase the frequency of the exercise as your knee becomes stronger.

Icing after exercise will help manage the discomfort that may occur. Icing can be administered by the Cryocuff, a bag of ice cubes, or a cold pack placed on your knee. Ice should be left on your knee for 10 minutes.

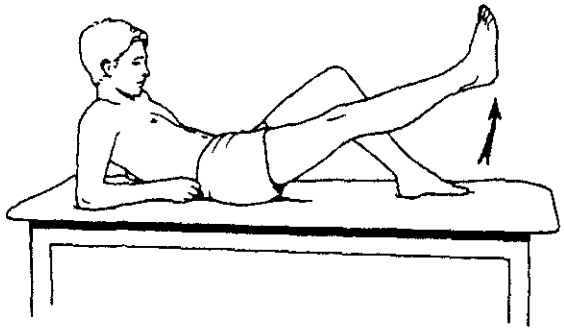
Perform your exercise routine 3 times/day, followed by icing.

1. QUADRICEPS SETTING.



Sit on a flat surface with legs out straight. Tighten the knee by pressing your knee into the flat surface. Hold for a count of 5 seconds. Relax and repeat slowly, holding the knee in the tightened position approximately 5 seconds each time. Repeat this exercise at least 25 times every hour; it can also be performed at odd moments, such as in the auto while waiting for a traffic light, sitting in a chair, etc.

2. STRAIGHT LEG RAISING.



Lie on your back with your involved leg out straight; Opposite knee bent, foot flat on floor. Lift your leg slowly off the bed. Raise the leg as high as possible. Slowly lower the leg to the bed, keeping the knee straight. Repeat ten times; perform exercise three times daily.

Nurse _____ Date _____ Patient _____

FAULKNER HOSPITAL

ACCT#: 23601656
ROLLINS, JAMES
09/11/2008
8 SHABAZZ WAY
BOSTON MA 02119
DOB: 08/12/1956

MR#: 01018512
BLEY, LOUIS
AGE: 52 SEX: M

PREOPERATIVE ORDERS

State date and time for all orders
All orders must be signed

	Date/Time Started	Signature
ALLERGIES NKMA		
☐ **NO PREOPERATIVE ANTIBIOTICS NEEDED**		
☐ **DELAY ANTIBIOTIC UNTIL AFTER INTRAOPERATIVE CULTURE**		
GROUP ONE ANTIBIOTICS: ☒ *CEFAZOLIN* ☐ *1 GM* ☐ *2 GM* ☐ *3 GM INTRAVENOUSLY 0-60 MINUTES PRIOR TO SKIN INCISION* IF B-LACTAM ALLERGY: ☐ VANCOMYCIN ☐ 1 GM INTRAVENOUSLY 0-120 MINUTES PRIOR TO SKIN INCISION OR ☐ CLINDAMYCIN ☐ 600 mg ☐ 900 mg INTRAVENOUSLY 0-60 MINUTES *PRIOR TO SKIN INCISION* IF SIGNIFICANT RISK FOR MRSA: ☐ VANCOMYCIN ☐ 1 GM INTRAVENOUSLY 0-120 MINUTES PRIOR TO SKIN INCISION	9.11.08 1330	costigan cms
GROUP TWO ANTIBIOTICS: ☐ CEFOXITIN ☐ 1 GM ☐ 2 GM INTRAVENOUSLY 0-60 MINUTES PRIOR TO SKIN INCISION OR ☐ CEFAZOLIN ☐ 1 GM ☐ 2 GM and METRONIDAZOLE ☐ 500 mg ☐ 750 mg INTRAVENOUSLY 0-60 MINUTES PRIOR TO SKIN INCISION OR IF B-LACTAM ALLERGY, CHOOSE ONE OF THE FOLLOWING ANTIBIOTIC GROUPS: GIVE INTRAVENOUSLY 0-60 MINUTES PRIOR TO SKIN INCISION ☐ CLINDAMYCIN ☐ 600 mg ☐ 900 mg GENTAMICIN ☐ 80 mg ☐ 120mg OR ☐ METRONIDAZOLE ☐ 500 mg ☐ 750 mg GENTAMICIN ☐ 80 mg ☐ 120 mg OR ☐ METRONIDAZOLE ☐ 500 mg ☐ 750 mg LEVOFLOXACIN ☐ 500 mg ☐ 750 mg IF SIGNIFICANT RISK FOR MRSA: ☐ VANCOMYCIN ☐ 1 GM INTRAVENOUSLY 0-60 MINUTES PRIOR TO SKIN INCISION		
ANTICOAGULANTS: ☐ YES ☐ NO ☐ HEPARIN 5000 UNITS SUBCUTANEOUSLY OR ☐ HEPARIN 7500 UNITS SUBCUTANEOUSLY OR ☐ LOVENOX 40 mg SUBCUTANEOUSLY		

DATE: 9 / 11 / 08 TIME: _____ SIGNATURE _____ MD BEEPER #: _____

GROUP ONE - CARDIAC THORACIC, VASCULAR, NEUROSURGICAL, ORTHOPEDIC, TRAUMA, HEAD/NECK, BILIARY
GROUP TWO - GENITOURINARY, BARIATRICS, COLORECTAL, APPENDECTOMY, HYSTERECTOMY (GYN)

FAULKNER HOSPITAL
DOCTORS ORDER
STATE DATE AND TIME FOR ALL ORDERS
ALL ORDERS MUST BE SIGNED

ACCT#: 2316537
ROLLINS, JAMES
09/11/2008
8 SHABAZZ WAY
BOSTON MA 02119
DOB: 08/12/1956

MR#: 01018512
BLEY, LOUIS
AGE: 52 SEX: M

ALLERGIES

DATE	TIME	
9.11.08		LR @ 100 cc/h PO AC to 1 Percocet i-2 po q 4° prn Ice (R) knee CN ✓ + loc WBAT
		Noted [illegible]

61880EZ (6/08)

WorkflowOne

FAULKNER HOSPITAL ACCT#: 23691656 **MR#: 01018512**

DOCTORS ORDER

ROLLINS, JAMES
09/11/2008
8 SHABAZZ WAY
BOSTON MA 02119
DOB: 08/12/1956

BLEY, LOUIS

AGE: 52 SEX: M

STATE DATE AND TIME FOR ALL ORDERS
ALL ORDERS MUST BE SIGNED

ALLERGIES

DATE	TIME	POSTOPERATIVE ANESTHESIA ORDERS - FOR PACU USE ONLY
9/11/08		☐ 1. Admit to PACU
		☐ 2. *Oxygen:*
		☐ Oxygen via face mask at 8 liters/minute to keep SaO2 greater than 92%
		☐ Oxygen via nasal cannula 2 liters/minute to keep SaO2 greater than 92%
		☐ Ventilator settings:

Tidal Volume	Rate	Mode	FiO_2	Peep

☐ 3. Analgesics (check only one dosage regime for any particular analgesic).

Morphine	☑ *Morphine 2 mg* ☐ Morphine 4 mg	*intravenously every 5 minutes as* needed for pain. Maximum 20 mg	☑ 1st ☐ 2nd ☐ 3rd ☐ 4th
Fentanyl	☐ Fentanyl 25 mcg ☐ Fentanyl 50 mcg	intravenously every 5 minutes as needed for pain. Maximum 1 mcg	☐ 1st ☐ 2nd ☐ 3rd ☐ 4th
Hydromorphone	☐ Hydromorphone 0.2 mg ☐ Hydromorphone 0.4 mg	intravenously every 5 minutes as needed for pain. Maximum 2 mg	☐ 1st ☐ 2nd ☐ 3rd ☐ 4th
Meperidine	☐ Meperidine 12.5 mg (Shivering)	intravenously one time as needed for shivering	☐ 1st ☐ 2nd ☐ 3rd ☐ 4th
Other	☐ Other: _____	____ mg every 5 minutes as needed for pain. Maximum ____ mg	☐ 1st ☐ 2nd ☐ 3rd ☐ 4th
Ketorolac	☐ Ketorolac 15 mg ☐ Ketorolac 30 mg	intravenously if not given in previous 6 hours	☐ 1st ☐ 2nd ☐ 3rd ☐ 4th

☐ 4. Antiemetics (indicate up to 4 medications and specify the order in which they should be given).

Medication Regime - specify medication(s) to be administered		
Ondansetron	*4 mg intravenously as needed for nausea/vomiting*	☑ 1st ☐ 2nd ☐ 3rd ☐ 4th
Dexamethasone	4 mg intravenously as needed for nausea/vomiting	☐ 1st ☐ 2nd ☐ 3rd ☐ 4th
Ephedrine	25 mg intramuscularly as needed for nausea/vomiting	☐ 1st ☐ 2nd ☐ 3rd ☐ 4th
Hydroxyzine	____ mg intramuscularly as needed for nausea/vomiting	☐ 1st ☐ 2nd ☐ 3rd ☐ 4th
Benedryl	____ mg intravenously as needed for nausea/vomiting	☐ 1st ☐ 2nd ☐ 3rd ☐ 4th
Famotidine	20 mg intravenously as needed for nausea/vomiting	☐ 1st ☐ 2nd ☐ 3rd ☐ 4th
Scopolamine Patch	1.5 mg transdermal patch behind ear as needed for *nausea/vomiting*	☐ 1st ☐ 2nd ☐ 3rd ☐ 4th
Other		☐ 1st ☐ 2nd ☐ 3rd ☐ 4th

☐ 5 Diagnostic testing and miscellaneous orders

☐ CXR ☐ EKG ☐ Accucheck ☐ Lab Work: _____

☑ 6. Discharge when criteria met.

☐ 7. Other Orders:

M.D. _____ BEEPER # 3961 DATE 9/11/08 TIME 1250

BRIGHAM AND WOMEN'S HOSPITAL

DANA-FARBER CANCER INSTITUTE

FAULKNER HOSPITAL

TEACHING AFFILIATES OF HARVARD MEDICAL SCHOOL

ACCT#: 2361656
ROLLINS, JAMES
09/11/2008
8 SHABAZZ WAY
BOSTON MA 02119
DOB: 08/12/1956

MR#: 01018512

BLEY, LOUIS

AGE: 52 SEX: M

PATIENT MUST BE IDENTIFIED BY NAME AND MEDICAL RECORD NUMBER

CONSENT FOR PROCEDURE

PROCEDURE: Right Knee Arthroscopy, Partial Meniscectomy

I understand the nature of my condition, the nature of the procedure, and the benefits to be reasonably expected compared with alternative approaches as has been explained to me.

I understand that there is a chance that major risks or complications of the procedure may occur, including (if applicable) but not limited to infection, hemorrhage, drug reactions, blood clots, loss of sensation, loss of limb function, paralysis, brain damage and loss of life. I also understand that with any procedure, there is always the possibility of an unexpected complication, and no guarantees or promises have been made to me concerning the results of any procedure or treatment. I also understand that unexpected findings may compel my surgeon to perform additional or alternate procedures not hereir described.

Specific additional risks for this procedure, if applicable, may include, but are not limited to:

Infection

Bley will perform the procedure. The procedure may also involve the participation of resident physicians, fellows and/or physician assistants. My physician will determine when it is necessary for others to participate in my care.

I understand that it is possible that one or more healthcare industry professionals (technical representatives for medical equipment and device companies) may be present during this procedure for advisory purposes only.

I understand that blood or other specimens removed for necessary diagnostic or therapeutic reasons may later be disposed of by the hospital. These materials also may be used by BWH / FH/ DFCI, or other academic or commercial entities for research, educational purposes (including photographing), or other activity, if in furtherance of the Hospital's missions.

Since aspects of this procedure may have educational value, data, video or photographs may be obtained for teaching purposes, presentations at medical/scientific meetings or publications in medical scientific journals. All such recordings used for teaching purposes will be de-identified.

CONSENT FOR THE USE OF BLOOD PRODUCTS: I understand that there is sometimes a need for blood products during the procedure, and that the benefits from receiving blood products outweigh the associated risks. A Blood Transfusion Information Sheet, which describes the risks, benefits and alternatives to transfusion is available should I have questions. I have had an opportunity for my questions about blood transfusion to be answered.

FAULKNER HOSPITAL

ANESTHESIA CONSENT FORM

ACCT#: 2360 1656 **MR#: 01018512**

ROLLINS, JAMES
09/11/2008
8 SHABAZZ WAY
BOSTON MA 02119
DOB: 08/12/1956

BLEY, LOUIS

AGE: 52 SEX: M

Dr. Zhang has explained to me that a member or members of the Department of Anesthesia will induce anesthesia for relief of pain during the procedure(s) set forth on the Procedure Consent Form.

I understand that anesthesia involves a potential for risks including, and in addition to, those described on the Procedure Consent form. These risks may include such things as injury to teeth, allergic reaction, damage to vocal cords, cardiac and / or respiratory problems, pain and discomfort, headaches, and loss of sensation or life.

I acknowledge that I have discussed the use of anesthesia or conscious sedation with a member of the Department of Anesthesia, who has explained the risks of the use of anesthesia or conscious sedation. All of my questions have been answered to my satisfaction.

I understand that due to the reversible nature of perioperative events and the intrinsic life support character of anesthesia, Do-Not-Resuscitate (DNR) status can be suspended during the performance of invasive procedures requiring anesthesia or conscious sedation. The DNR orders are then reinstituted after performance of the procedure and discharge from Post Anesthesia Care. I may, after consultation with my physician, request specific limitations to treatments as noted below.

After discussion, if there are no specific limitations to treatment, I give consent to suspend "Do-Not-Resuscitate" orders during the surgery and post anesthesia care.

X _____ 9/11/08
Patient's Signature Date

_____ 9/11/08
Anesthesiologist's Signature Date

FAULKNER HOSPITAL

9/11/08 rescheduled per Dr. Bley's office

DAY SURGERY
PREOPERATIVE CHECKLIST AND ASSESSMENT

ACCT# 23601656 **MR: 01018512**
ROLLINS, JAMES
09/11/2008 BLEY, LOUIS
8 SHABAZZ WAY
BOSTON MA 02119
DOB: 08/12/1956 AGE: 52 SEX: M

Rollins, James

Date of Surgery ~~9/16/08~~ 9/12/08 | Surgeon Bley | Type of Admission Day Surgery (DS)

Home Telephone 617-999-0577 | Work Telephone cell

Procedure Right knee Arthroscopy

Birth date 8/12/56 | Age 52 | OR Time ~~1720~~ 1315 | Arrival Time ~~1500~~ 1200

PREOP TESTING | Testing Source ☐ Clinic ☐ PCP ☐ DMA ☑ HV ☐ MR ☐ Other ______

HEALTH MANAGEMENT PATTERN | PRIMARY PROVIDER OF HEALTH CARE HV-Boston | Date of preop physical visit ______

HCT 44.7 EKG 5/20/08 1° AV Block
BS
BUN 17 CXR
CREAT 1.21

12.0 6/8

H & P ☐ DOS ☒ DONE ☐ Update Needed (within 7-30 days)
Date of H & P 8/12/08
Old Medical Record ☐ Yes ☐ No CF If Yes, Reviewed ☐

Additional testing needs: K 4.2 — 5/08 Cardiology Consult, 6/9/08 (-) Stress

	Requested	Received
Cardiology consult	☒	☒
EKG clearance by PCP	☐	☐
Pulmonary consult	☐	☐

Testing present at time of CPE appointment ☐ Yes ☒ No

MD office notified of H & P/Testing deficit ☐ Date(s) Office Called ATN - Cardiology RN

Note · 8/27/08 1230 Spoke c̄ HV - will fax Cardiac Clearance [illegible]

PRE-SCREENING APPOINTMENT CALL (if applicable) | PAT Appointment Date 8/28/08 Time: 1030 ☒ AM ☐ PM

TIME OF ARRIVAL: ______ ☐ AM ☐ PM ☐ MAY EAT AND TAKE ALL SCHEDULED MEDICATIONS

BRING A LIST OF ALL MEDICATIONS (INCLUDING OTC, HERBAL) THAT YOU TAKE. ☐

COMMENTS: 8/26/08 left voice mail @ 1130 Am [illegible]
8/27/08

Interpretive Service Needed Y ☐ N ☐ If yes - interpreter contacted ☐ Date: RN

PREOP CALL AND INTERVIEW | Date 9/10/08 | Time 3 ☐ AM ☒ PM

☒ Nothing to eat or drink after midnight
☒ Take medications DOS Metoprolol, lisinopril (clears till 10 AM)
☒ Leave valuable items at home.
☒ No colored nail polish, makeup, jewelry, contact lenses or hair pins
☒ Responsible adult to take patient home at anytime
☒ Bring eyeglass case

9/10 [illegible]

8/28/08 all above info given & reviewed. [illegible] RN

* pt doesn't take anything for acid reflux. 9/10 3P [illegible]

9/3/08 4:20P [illegible] 9/3/08 - arrival time given to father [illegible]

CURRENT MEDICATIONS: PRESCRIPTIONS OR "OVER THE COUNTER" DRUGS OR HERBAL SUPPLEMENTS

NAME OF DRUG	DOSE/FREQUENCY	TIME OF LAST DOSE	NAME OF DRUG	DOSE/FREQUENCY	TIME OF LAST DOSE
Metoprolol	SR 25mg	9/11/08 4pm			
Simvastatin	80mg	9/11/08 4pm			
Lisinopril	20mg	9/11/08 4pm			
ASA 81mg		dc'd X 3 wks.			
MVI		dc'd X 3 wks.			

DAY SURGERY PRE-ADMISSION ASSESSMENT

DOMESTIC VIOLENCE/ABUSE

Do you feel unsafe or afraid of anyone (e.g. your partner, a relative, or anyone else)? ❑ Yes ❑ No If yes, who? ______
Is anyone trying to control you (e.g. where you go, who you talk to, what you wear, how you spend money)? ❑ Yes ❑ No If yes, who? ______
Has anyone hurt you, threatened to hurt you or someone that you care about? (For example, has anyone hit, slapped, or kicked you or forced you to perform sexual acts against your will)? ❑ Yes ❑ No If yes, who? ______

FALL RISK

Circle appropriate score. Choose one score per item number.

1. History of Falling	yes = 25	no = 0	5. Gait		
2. Secondary Diagnosis	yes = 15	no = 0		A. Normal/bedrest/wheelchair	yes = 0
3. Ambulatory Aid				B. Weak	yes = 10
A. None/bedrest/nurse assist	yes = 0			C. Impaired	yes = 20
B. Crutches/cane/walker	yes = 15		6. Mental Status		
C. Furniture	yes = 30			A. Oriented to own ability	yes = 0
4. IV Therapy/Heparin Lock	yes = 20	no = 0		B. Overestimates/forgets limitations	yes = 15

FALL TOTAL (1-6): 0

Risk for Physiological Fall: NO RISK = 0 LOW RISK = 1-24 MODERATE RISK = 25-45 HIGH RISK = >45

** If RISK SCORE is 36 or more put an ORANGE armband on patient **

Mobility: ❑ Ambulate ❑ Cane ❑ Crutches ❑ Walker ❑ Wheelchair
Difficulty with ADL ❑ Yes ❑ No Recent Falls ❑ Yes ❑ No Swallowing Problem ❑ Yes ❑ No
Appetite changes ❑ Yes ❑ No Weight Loss greater than 10 lbs. in last 3 months ❑ Yes ❑ No
If yes to functional or nutritional assessment, patient advised to see PCP for evaluation and treatment ❑ Yes

PAIN ASSESSMENT

Level of consciousness: alert and oriented ✓
easily aroused ______
difficult to arouse ______
somnolent ______

Do you have pain now? ☒ Yes ❑ No
Pain location right knee
Have you had this pain before? ❑ Yes ❑ No
Pain intensity: # 6-7 Scale used: Verbal Numeric (0-10) ✓
FLACC (0-10) ______
Facial Numeric (0-10) ______
Infant (0-10) ______

Pain Onset/Duration: long time
Pain Quality: Sharp ______ Dull ______ Stabbing ______ Pressure ______ Throbbing ______ Burning ______
and/or in patient's own words: ______
Pain Patterns: Intermittent ✓ Constant ______ Both ______
Aggravating Factors: certain movements
Relieving Factors: Rest
Current Pain Management: 0
Patient's Pain Goal (0-10) — 0

Educational Goals Met; patient informed:

✓ Pain management is an important part of your treatment.
✓ Your opinion about how to manage your pain is important.
✓ You can expect a timely response to reports of pain.
✓ Pain information booklet was given.

Patient advised to see PCP for evaluation and treatment of pain ❑ Yes ❑ No ❑ Not Applicable

Comments: ______

[signature] RN 8/28/06 Date

Do you have any other pain? ❑ Yes ☒ No
Describe (if yes): If yes, proceed to "Secondary Pain Assessment" form.

DAY SURGERY PRE-ADMISSION ASSESSMENT

SYSTEM	MEDICAL HISTORY	SURGICAL HISTORY
Cardiovascular ☐ Denies problems	☒ +MI ☐ Murmur ☒ CAD ☒ HTN ☐ Angina ☐ CHF ☐ PVD ☒ Cholesterol ☐ MVP ☐ Palpitations ☐ AFIB ☐ Other ☐ Pacemaker ☐ AICD	1° AV Block Cardiac Cath S/P Viral Myocarditis
Pulmonary ☐ Denies problems	☐ COPD ☐ Bronchitis ☐ Asthma ☐ Pneumonia ☐ Other: ☐ TB ☐ Sleep Apnea * ☐ CPAP Machine ☐ Smoking cessation pamphlet given	(+) PPD treated 2003 Smoker: ☐ No ☐ Yes _____ / _____ pack years
Genito-Urinary ☐ Denies problems	☐ UTI ☐ Stone ☒ Kidney Failure ☐ Other: chronic - mild ☐ BPH ☐ Stress Incontinence ☐ Bladder Tumors	
Hepatic ☐ Denies problems	☐ Hepatitis ☐ Cirrhosis ☐ GB Disease ☐ Other: ☐ Jaundice	
Neurological ☐ Denies problems	☐ CVA ☐ Headaches ☐ Impaired vision/hearing ☐ Seizures ☐ Other:	
Gastro-Intestinal ☐ Denies problems	☐ Ulcers ☐ Bowel Problems ☐ Hiatal Hernia ☒ Acid Reflux ☐ Other:	
Hematological / Dermatological ☐ Denies problems	☐ Anemia ☐ Bleeding Disorders ☐ Other: Skin Color/Integrity: _____	Rectal bleeding S/P appy S/P CHS
Endocrine / Metabolic ☐ Denies problems	☐ Diabetes Type I ☐ Thyroid ☒ Diabetes Type II	
Musculoskeletal ☐ Denies problems	☐ Arthritis ☐ Fracture ☐ Back/Neck Injury ☐ Gait Disturbances ☐ Other:	(R) knee injury 1/68 S/P MVA 11/67 - whiplash & Rom
OB/GYN ☐ Denies problems	☐ Menopause ☐ LMP _____ ☐ Other: _____	
Psycho / Social ☐ Denies problems	☐ Anxiety ☐ Depression ☐ Other: _____	**Primary Language** English Level of Consciousness ☒ Alert ☐ Oriented ☐ Disoriented Present Behavior: ☐ Talkative ☐ Lethargic ☐ Cooperative ☐ Anxious ☐ Combative Living Situation: @ home Family/Significant Others: Kristen Drugs ☒ No ☐ Yes _____ Alcohol ☒ No ☐ Yes _____ If yes, how much _____ how often _____ If yes, how much _____ how often _____

Resources for Social Support ☐ V.N.A. ☐ Day Care ☐ Home Health Aide ☐ Home Maker ☐ Hospice ☐ Meals on Wheels ☐ None needed

NURSING OBSERVATIONS Spoke to pt on phone screen pre op teaching reviewed.

Crutch training completed: ☐ Yes ☐ Not Applicable Health Care Proxy Form: ☐ Given ☐ Declined not

PREOP/PROCEDURE INSTRUCTIONS:
- ☐ Pre-Procedure instructions provided and feedback indicated patient understanding.
- ☐ Patient unable to give feedback secondary to condition.
- ☐ Pre-procedure instructions provided to responsible adult and feedback indicated understanding.

BARRIERS TO LEARNING: none

PERTINENT CULTURAL PRACTICES: none

Signature: _____ RN Date 8/28/08

PREOPERATIVE CHECKLIST

O_2 SAT	RESP RATE	RHYTHM	DESCRIBED BREATH SOUNDS	PULSE	RHYTHM	BP	TEMPERATURE
97%	20	reg	Bilat clear breath sounds	58	reg	127/66	96.8

Patient has Pacemaker ☐ AICD ☐

PATIENT'S UNDERSTANDING OF PROCEDURE Right Knee Arthroscopy

ALLERGIES: NKA

Height: 6'1" Weight: ~~240~~ 109 ~~lbs~~ Kg. 402.

hayfever seasonal -

Nothing by mouth since: 7 ☑ AM ☐ PM

LAST VOID: ☐ AM ☐ PM

Latex Allergy: ☐ Yes ☒ No If yes, OR notified ☐

LEVEL OF CONSCIOUSNESS: ☑ Alert ☑ Oriented ☐ Disoriented

Attention Span: attentive

Present Behavior: ☑ Talkative ☐ Lethargic ☑ Cooperative ☐ Anxious ☐ Combative ☐ Depressed ☐ Unresponsive ☐ Other

Mobility: ☑ Ambulate ☐ Cane ☐ Crutches ☐ Walker ☐ Wheelchair

Body Posture: erect

PATIENT SIGNED CONSENT	☐ Yes ☐ No		HAIRPINS, MAKE-UP AND NAIL POLISH REMOVED	☐ Yes ☐ No	☑ N/A
PHYSICIAN SIGNED CONSENT	☐ Yes ☐ No		PROSTHESIS REMOVED	☐ Yes ☐ No	☑ N/A
ID BAND ON PATIENT	☑ Yes ☐ No		HEARING AID REMOVED	☐ Yes ☐ No	☑ N/A
VALUABLES, JEWELRY REMOVED	☑ Yes ☐ No		EYE GLASSES / CONTACT LENSES REMOVED	☐ Yes ☐ No	☑ N/A
TATTOOS	☐ Yes ☑ No		DENTURES REMOVED	☐ Yes ☐ No	☑ N/A
			BODY JEWELRY REMOVED	☐ Yes ☐ No	☑ N/A

NAME, TELEPHONE NUMBER AND LOCATION OF PERSON TO CONTACT AFTER SURGERY

NAME: DAD + Mom (home)

LOCATION: JAMES + Ell @ TELEPHONE # 508-428-9943

NURSING OBSERVATIONS

Admission Date: 9/11/08 Time: 11 Am

Preop checklist completed: ☑ Yes

Patient verbalizes understanding of preop and postop instructions ☑ Yes ☐ If No, explain:

Patient assisted to anesthesia holding area, placed on

- stretcher ☑
- recliner ☐

Discharge plan:

☑ Home with responsible adult, written instructions and follow-up with MD.

J Humphrey RN

HEALTH CARE PROXY ☐ Yes ☑ No If yes, Health Care Proxy Agent: Name Phone

COPY IN CHART ☐ Yes ☑ No

Pre-Admission Assessment reviewed Yes ☑

Revised Day of Surgery ☐ Yes ☑ Not Applicable

NURSING DIAGNOSIS	EXPECTED OUTCOME	INTERVENTIONS	SIGNATURES	INITIALS
1. Knowledge deficit re: perioperative process.	Patient will ask pertinent questions and verbalize understanding of what is expected in the perioperative period.	Inform about preop and postop procedures and restrictions. Review preop and postop instructions.	Rachael Lebofsky J Humphrey	RL JH
2. Anxiety, fear of the unknown.	The patient expresses feeling of comfort and lessened anxiety prior to anesthetic induction.	Assess level of anxiety and possible causes, taking appropriate action.		

FAULKNER HOSPITAL
OPERATING ROOM VERIFICATION CHECKLIST
FOR SURGICAL SITE

ACCT#: 23601656
ROLLINS, JAMES
09/11/2008
8 SHABAZZ WAY
BOSTON MA 02119
DOB: 08/12/1956

MR#: 01018512
BLEY, LOUIS
AGE: 52 SEX: M

Date of Surgery: J Humphrey RN

Patient Identification	☐ Name ☑ Birthdate	RN Signature: J Humphrey RN
Patient Verification of Operative Site Date/Procedure: Knee	Left / Right / NA	RN Signature: J Humphrey
See noted on Preoperative Checklist / Flowsheet Knee	Left / Right / NA	RN Signature: J Humphrey
Site noted on Informed Consent	Left / Right / NA	RN Signature: A Rodeheaver
Site noted on History & Physical Knee	Left / Right / NA	RN Signature: J Humphrey
Site noted on Perioperative Record	Left / Right / NA	RN Signature: A Rodeheaver
Physician noted site on X-rays (etc.) (as appropriate)	Left / Right / NA	RN Signature: A Rodeheaver
Site marked by Surgeon	Left / Right / NA	RN Signature: A Rodeheaver
VERBAL CONSENSUS (TIME OUT) of patient ID, procedure, site and side, correct patient position, availability of implants and any special equipment or special requirements by surgical team in the OR suite	Left / Right / NA	RN Signature: A Rodeheaver RN
	Left / Right / NA	Surgeon Name: DR Bley
	Left / Right / NA	Anesthesia Name: E Ostoguy CRNA
Prophylactic Antibiotic started within 60 minutes to 0 minutes of incision time	☑ Yes ☐ No ☐ N/A	RN Signature: A Rodeheaver RN

1346
Time of "Time Out"

Circle **Left or Right** as appropriate *N/A Not Applicable

14EZ (5/08)

WorkflowOne

Faulkner Hospital Anesthesia Record

DATE 09-11-2008 OR# 7 PS

ANESTHESIOLOGIST / TIME	ASSESSED IMMED. PREINDUCTION	PRESENT FOR INDUCTION	IMMEDIATELY AVAILABLE	EMERGENCE	CRNA / RES / TIME	INITIALS
1. [signature]	Zha	Zha	Zha	Zha	Emilie Stigney CRNA	cos
2.						
3.						
4.						

IDENTIFICATION 21600656 01018512

COLLINS, JAMES cos
05/12/1956 BLEY, LOUIS M.D.
SHABAZZ WAY BOSTON
09/11/2008

510, NKDA, 1091

POSTOP DIAGNOSIS: Right knee med. meniscal chondromalacia tear

OPERATIVE PROCEDURE: Right knee arthroscopy; Med meniscal repair

PREP/START 1322 · OR START 1332 · OR STOP 1411 · RR STOP 1421

MACH # G · MACHINE CHECK cos · EKG IV · AUTO BP RUE · OXIMETER LUE · END TIDAL CO2 ✓ · TEMP po

EYE PROT paper · NERVE STIM · BAIR HUGGER VB 093 c · PLACED BY ANES: ☐ CVP ☐ PA ☐ A LINE

WASTED CONTROLLED MEDS

DRUG	ANESTHETIST	WITNESS

PREMEDS DOSE TIME: Versed 2mg; ~~Fentanyl~~ mg

SURGEONS: BLEY

☐ NERVE BLOCK ☐ BLOCK FOR POSTOP PAIN ☑ GA (LMA) ☐ MAC ☐ SPINAL ☐ EPIDURAL

O2: % – ½ – 3/8 – % · Sevo (%): 2.5 – 1.5

CONTROLLED SUBSTANCES

TAKEN	RETURNED	Drug
1	0	MIDAZOLAM (2)
2	1	FENTANYL (50)

Chart Intravenous Antibiotics on Intravenous Antibiotic Order Sheet — CEFAZOLIN 2gm preop

Drug / item	Totals
MIDAZOLAM	2mg
FENTANYL	100mcg
Lido.	
PROPOFOL	
Decadron	5mg
Zofran	4mg
Ephedrine	
Robinul	
LR ↑ (FLUIDS)	500cc
BLOOD	
BLOOD LOSS	min.
URINE	DTV

PARAMETERS: OXIMETER 100; ECG SR; ETCO2 58; FIO2 1.0; T° po; ET Sevo 1.4 / 2.0 / 0.2; CRNA / RESIDENT cos; ANESTHESIOLOGIST ZHA

INDUCTION / BLOCK / IV'S: IV SIZE 20 SITE (L) hand

INDUCTION: ☑ Intravenous ☐ Inhalational ☐ Rapid sequence ☐ Cricoid pressure (*Comment below)

MASK VENTILATION: ☐ None ☑ Easy ☐ Difficult*

AIRWAY: ☐ Mask ☐ ETT ☑ LMA #5 x1 easily

INTUBATION: ☐ Oral ☐ Nasal ☐ In-situ/Trach

Blade(s)/Style: ____ Visualization (Circle) I II III* IV* (*Comment below) ETT Size ___ mm Fixed @ ___

☑ BBS ☐ ETCO2 ☑ Atraumatic Insertion LMA (3)

REGIONAL ☐ Sterile technique ☐ Block site confirmed ____ initials
Spinal Position ____ Epidural Level ____ Other* Needle(s) ____ Attempts ____
Paresthesia ☐ No ☐ Yes* (*describe below)
Agent Dose/Concentration ____

Time: 13:00, 13:30, 14:00, 14:30, 15:00, 15:30, 16:00, 16:30, 17:00 · PACU

Chart notes: Arm ppt; Eyes taped/protected; Spine neutral

PREINDUCTION VITAL SIGNS ARE THE FIRST VITAL SIGNS RECORDED ON THIS RECORD

PACU: BP 124/56; P 64; R 14; SAT 100%; COND

PATIENT SAFETY: ☑ Safety belt on ☐ Ax. Roll ☑ Eyes protected ☑ Armboard Restraints ☐ Arms tucked <90; supine ☑ Pressure areas check and padded

INCISION TIME: ⊙ = 1348 (See 815 VS)

Spont. breathing. 420 x 10. LMA D/C'd. Teeth intact as preop. To RR c 100% O2 FM. Report to RN.

TV	383	192	220
RATE	18	12	14
PIP	SV	SV	SV
P.P. & eye ✓	✓	✓	✓
PT. Position	⊙ ←	—	—
TOURN.			

10002 1/08 WHITE - Medical Records YELLOW - Anesthesia PINK - Pharmacy PAGE OF

Faulkner Hospital
PERIOPERATIVE PATIENT RECORD

Date 9/11/08 ☐ Inpt. Rm. # _____

☑ DS ☐ 23 hour Admit ☐ AM

ACCT# 23601656 **MR: 01018512**
ROLLINS, JAMES
09/11/2008 BLEY, LOUIS
8 SHABAZZ WAY
BOSTON MA 02119
DOB: 08/12/1956 AGE: 52 SEX: M
PATIENT IDENTIFICATION AREA

Scheduled Procedure Right Knee ARTHROSCOPY W/ MENISCECTOMY

Allergies NKDA ☐ Body Substance Isolation _____

PREOPERATIVE Age 52 Weight 109 kg Height 6'

NURSING DIAGNOSIS	EXPECTED OUTCOME	NURSING APPROACH	EVALUATION
Potential for anxiety related procedure, position, and fear of outcome of procedure	Patient will have improved ability to cope with anxiety	• Explain all procedures to patient prior to being anesthetized. • Allow patient to verbalize fears. • Reassure patient as procedures are being performed. • Keep patient's exposure at a minimum level. • Keep OR room noise and traffic to a minimum at all times.	Demonstrated understanding of explanations ☑ YES ☐ NO If no, explain:

EMOTIONAL STATUS: ☐ Appears anxious ☑ Appears relaxed/calm ☐ Other: Comments _____

BEHAVIOR OBSERVED: ☑ Cooperative ☐ Confused ☐ Combative ☐ Other: Comments _____

R.N. Signature (Holding Area) _____ R.N. _____

INTRAOPERATIVE

Potential for alterations in skin integrity secondary to intraoperative position.	Patient's skin integrity will be maintained without injury.	• Maintain patient's body alignment. • Protect potential/actual pressure points. • Post procedure, assess skin integrity.	Tolerated procedure with no apparent injury ☑ YES ☐ NO If no, explain:
Potential for injury and/or infection secondary to surgery.	Patient will remain infection free.	• Maintain aseptic technique according to dept. policy and AORN standards. • Use appropriate prepping technique. • Complete required counts. • Place dispersive electrodes appropriately. • Have all equipment in proper working order.	Avoidance of patient infection attempted ☑ YES ☐ NO If no, explain:
Potential for fluid volume deficit.	Patient will maintain adequate circulating volume.	• Monitor outputs: urine, blood loss, etc. • Monitor amount of irrigation used. • Report all data to anesthesia care giver or surgeon as appropriate.	Reported all circulating volume data to surgeon and/or anesthesia care giver ☐ NA ☑ YES ☐ NO If no, explain:

65121 4/08

INTRAOPERATIVE

Operating Room Number 7 Patient Identified By ☐ ID Band ☒ Verbal

Time In 1332 Surgery #1 Start 1348 Surgery #2 Start

Time Out 1411 Surgery #1 End 1400 Surgery #2 End

SURGEON DR Bley

Assistant(s) 0

ANESTHESIOLOGIST DR Zong ANESTHETIST E Ostiguy CRNA

TYPE OF ANESTHESIA ☒ General ☒ LMA ☐ Spinal ☐ Local ☐ MAC ☐ Regional ☐ Epidural ☐ A-line ☐ CVP ☐ PA

Circulator Allredge Relieved by Time

Circulator Relieved by Time

Scrub A Jenkins ST Relieved by Time

Scrub Relieved by Time

PREOPERATIVE DIAGNOSIS Right knee medial meniscus tear

POSTOPERATIVE DIAGNOSIS same + chondromalacia

OPERATION Right knee arthroscopic medial meniscectomy

TRANSPORTATION TO O.R. ☐ Wheelchair ☒ Stretcher ☐ Bed ☐ Ambulatory ☐ Recliner Comments

SURGICAL TABLE ☒ Regular ☐ FX Table ☐ C-Arm Ext. ☐ Cysto Comments

OPERATING POSITION ☒ Safety Strap *(per policy)* ☒ Supine ☐ Prone ☐ Lateral RT/LT ☐ Lithotomy ☐ Semi-Fowler

Other Left Knee down c gel Comments approved by DR Bley

POSITIONAL AIDES ☐ Pillow ☐ Covered Bean Bag ☐ Bolster Roll ☒ Gel Pads ☐ Mayfield Headrest ☐ Padded Footboard

☐ Hand Table ☒ Head Headrest ☐ Wilson/Andrews Frame ☒ Padded Armboard ☒ Left ☐ Right

☐ Axillary Roll ☐ Gel Heel Protectors ☐ Padded Stirrups ☒ Arthroscopy leg holder ☐ Black Hip Positioner

☐ Other Positioned by Whom Staff: RN + Room Staff assist

SURGICAL SKIN PREP ☐ Betadine ☐ Phisohex ☐ Alcohol ☐ Zephiran ☒ Dura Prep *Hair Clipping* ☐ Yes ☒ No

Reaction ☐ Yes ☒ No Comments

ELECTROCAUTERY ☒ NA ☐ Yes; ID# Ground Pad Location ☐ Megadyne Coag

Cutting Condition of Skin Prep Postop

BIPOLAR ☒ NA ☐ Yes; ID#

TOURNIQUET ☒ NA ☐ Yes; Location Padded with Webril ☐ No ☐ Yes; Covered with steridrape ☐ Yes ☐ No

Pressure Checked PreOp ☐ No ☐ Yes, BY *Pressure Setting*

Time Up 1) 2) Time Down 1) 2) Total Time 1) 2)

PNEUMATIC COMPRESSION BOOTS ☒ NA ☐ Yes ID#

WARMING BLANKET ☐ NA ☒ Yes ID# 48017 ☐ Top ☐ Bottom

SPECIMENS OBTAINED:

☒ No ☐ Yes; Pathology # of Specimens

☒ No ☐ Yes; Frozen Section

☒ No ☐ Yes; Cultures Verified with DR Bley M.D.

SURGICAL COUNTS

Initial Count:

Sponge ☒ exempt ☐ Yes

Sharp ☒ exempt ☐ Yes

Instrument ☒ exempt ☐ Yes

Comments _____

RN Signature A Reddy RN

Scrub Name A Jenkins SN

2nd Closing Count:

Sponge ☐ exempt ☐ yes ☐ correct ☐ incorrect ☐ x-ray

Sharp ☐ exempt ☐ yes ☐ correct ☐ incorrect ☐ x-ray

Instrument ☐ exempt ☐ yes ☐ correct ☐ incorrect ☐ x-ray

Comments _____

RN Signature _____

Scrub Name _____

1st Closing Count:

Sponge ☐ exempt ☐ Yes ☐ correct ☐ incorrect ☐ x-ray

Sharp ☐ exempt ☐ Yes ☐ correct ☐ incorrect ☐ x-ray

Instrument ☐ exempt ☐ Yes ☐ correct ☐ incorrect ☐ x-ray

Comments _____

RN Signature _____

Scrub Name _____

3rd Closing Count:

Sponge ☐ exempt ☐ yes ☐ correct ☐ incorrect ☐ x-ray

Sharp ☐ exempt ☐ yes ☐ correct ☐ incorrect ☐ x-ray

Instrument ☐ exempt ☐ yes ☐ correct ☐ incorrect ☐ x-ray

Comments _____

RN Signature _____

Scrub Name _____

	TIME COMPLETED	RN SIGNATURE	SCRUB SIGNATURE
Permanent Relief Count			
Permanent Relief Count			

WOUND CLASSIFICATION ☒ Clean I ☐ Clean Contaminated II ☐ Contaminated III ☐ Dirty IV

URINARY CATHETER ☒ No ☐ Yes In O.R. ☐ Yes Inserted by _____ Size/type _____

URINE OUTPUT Initial _____ Color _____ Intraoperative _____ Color _____ Total _____

DRAINS ☒ No ☐ Yes Type _____ Location _____

Type _____ Location _____

EBL none

PACKS ☒ No ☐ Yes Type _____ Location _____

DRESSING ☐ Dermabond ☐ Benzoin ☐ Mastisol ☐ Steri Strip ☒ Xeroform/Adaptic

☐ Bacitracin Oint ☒ Dry Sponge ☒ ABD Pad ☐ Webril ☒ Kling/Kerlix

☒ Ace Wraps ☐ Eye Pads ☐ Fox Eye Shields ☐ Peri Pad & Mesh Pants

☐ Other _____

TAPE ☐ Dermicel ☐ Opsite/Tegaderm ☐ Microfoam ☐ Paper ☐ Elastoplast

☐ Application Splint/Cast ☐ Adhesive ☐ Other _____

MEDICATIONS ON SURGICAL TABLE _____ Solutions ☐ Ban ☒ LR

Lidocaine 1% epi 20cc prep by MD ☐ Glycine ☐ Saline

Marcaine 0.5% plain 30 cc prep by MD

FAULKNER HOSPITAL
POST-ANESTHESIA CARE UNIT

DATE SEP 11 2008 TIME IN 1411

ALLERGIES NKDA

AGE 52

ACCT# 23601656 **MR: 01018512**
ROLLINS, JAMES
09/11/2008 BLEY. LOUIS
8 SHABAZZ WAY
BOSTON MA 02119
DOB: 08/12/1956 AGE: 52 SEX: M

SURGEON/RESIDENT

ANESTHESIOLOGIST

TYPE OF ANESTHESIA ☐ GENERAL ☐ MASK ☐ MAC ☐ LOCAL ☐ EPIDURAL ☐ ETT ☐ LMA ☐ SPINAL ☐ REGIONAL

Intraoperative Meds: 2V 100f 4Z 5 Dec

local 20cc, 30cc

PROCEDURE (R) knee scope, medial menisectomy

PMH/PSH See anesthesia preop

PREOP VITAL SIGNS & LABS

BP 127/66 58
O_2SAT 97 ASA II
Wgt. 109 kg. Hgt 6'1
Hct ___ K ___ BS ___

AIRWAY

1. Mask
2. Nasal Cannula
3. Nasal Trumpet
4. Oral Airway
5. Ett
6. Trach
x - see note

TIME	1411	1415	1430	1445	1500	1515							
RHYTHM/PVC'S	SR	SR	SR	SB	SB	/	/	/	/	/	/	/	/
TEMPERATURE	97.2					97.7							
PULSE	62	60	59	50	51								
RESPIRATORY RATE	12	12	12	12	13								
BLOOD PRESSURE	124/56	127/54	127/58	130/69	113/68	129/76	/	/	/	/	/	/	/
FIO2 / Airway	6/1	6/1	6/1	6/1	6/1								
O2 Sat.	100	100	100	100	100	0 2							

PAIN ASSESSMENT

Quality
- Dull
- Burning
- Pressure
- Sharp
- Throbbing
- Other

Intensity
Communicative Patients
0-10

Intensity
Non-Communicative Patients
0-10
See FLACC Scale

Pharmacologic
P Pharmacological -see med sheet

Reassessment
Post Intervention
- Reassess Pain Scale if intervention given
- or -
N/A if no intervention

Nonpharmacologic Interventions
1. Cold/Ice
2. Heat
3. Positioning
4. Environmental
   - Shut Door
   - Dim Lights
5. Distraction
6. Massage
7. Music
8. Relaxation

Location of pain	(L) knee →					
Quality of pain	/	/	/	/	/	/
Intensity communicative Patient 0-10	0	0	0	0	0	0
Intensity Non-communicative Patient 0-10	0	0	0	0	0	0
Non-pharmacologic Interventions	1/3	1/3	1/3	1/3	1/3	1/3
Reassessment (DOCUMENTED BY PAIN SCALE AND/OR PROGRESS NOTES)	✓	✓	✓	✓	✓	✓

POST-ANESTHETIC RECOVERY SCORE

ACTIVITY MOVES ALL 4 EXTREMITIES ON COMMAND =2 MOVES ALL UNBLOCKED EXTREMITIES =1 MOVES NO EXTREMITIES =0	2	2	2	2	2	2
RESPIRATIONS ADEQUATE TIDAL VOLUME =2 DYSPNEA OR INADEQUATE TIDAL VOLUME =1 NO SPONTANEOUS RESPIRATIONS =0	2	2	2	2	2	2
CIRCULATION SYS. BP ± 20 MMHG PRE-ANESTHETIC LEVEL =2 SYS. BP ± 20-40 MMHG PRE-ANES. LEVEL =1 SYS. BP ± 40 MMHG PRE-ANES. LEVEL =0	2	2	2	2	2	2
CONSCIOUSNESS FULLY AWAKE =2 AROUSABLE =1 NON-RESPONSIVE =0	1	1	1	1	1	2
OXYGEN SATURATION SPO2 GREATER THAN 92% ON RA =2 SPO2 GREATER THAN 90% SUPP. 02 =1 SPO2 LESS THAN 90% wSUPP. 02 =0	1	1	1	1	1	2
TOTAL SCORE	8	8	8	8	8	10

DISCHARGED BY CRITERIA: [signature] RN

TIME OUT 16:16

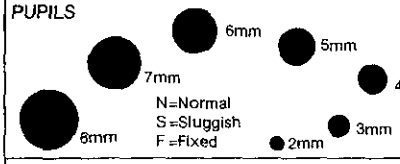
DISCHARGED TO Home c Dad

DISCHARGE SCORE 10

67150 7/07

TIME		ADM	DC
EYES OPEN	1. SPONTANEOUS		✓
	2. TO SPEECH	✓	
	3. TO PAIN		
	4. NONE		
MOTOR RESPONSE			
1. OBEYS COMMANDS		✓	✓
2. NO RESPONSE TO COMMANDS			
3. RESPONDS TO PAINFUL STIMULI			
4. PURPOSELESS MOVEMENT			
5. DECORTICATE			
6. DECEREBRATE			
MOTOR STRENGTH	L ARM	4	4
4=NORMAL STRENGTH	L LEG	4	4
3=LIFTS AND HOLDS	R ARM	4	4
2=LIFTS AND FALLS BACK	R LEG	3	3
1=MOVES ON BED	TOTAL	15	16
0=NO MOVEMENT			

PUPILS



	L	R
	/	

SKIN	ADM	DC
WARM	✓	✓
DRY	✓	✓
INTACT	✓	✓
COOL		
DIAPHORETIC		
SEE NOTE		
ABDOMEN		
SOFT	✓	✓
FLAT		
TENDER		
NON TENDER	✓	✓
DISTENDED		
NAUSEA Y/N	N	N
PALPABLE Y/N	N	N
BLADDER		
SEE NOTE		

RESPIRATION	ADM	DC
REGULAR	✓	✓
DEEP		
SHALLOW		
LABORED		
UNLABORED	✓	✓
SEE NOTE		
DRESSING		
DRY AND INTACT	✓	✓
LOCATION R knee		
SEE NOTE		
IV SITE		
PATENT	✓	✓
NO REDNESS	✓	✓
NO SWELLING	✓	✓
SEE NOTE		
SAFETY CHECK		
ALARMS ON	✓	✓
BOTH SIDERAILS UP	✓	✓
BRAKES ON	✓	✓
SEE NOTE		

BREATH SOUNDS	ADM	DC
CLEAR	✓	✓
RHONCHI		
WHEEZES		
RALES		
ABSENT		
DIMINISHED		
SEE NOTE		
BEHAVIOR		
COOPERATIVE	✓	✓
CRYING		
WITHDRAWN		
TALKATIVE		
RESTLESS		
CALM	✓	✓
COMBATIVE		
ANXIOUS		
SEE NOTE		

RESPIRATORY CARE

TIME	INITIALS	FIO_2	MECHANICAL: VENT RATE/PT. RATE	MODE	T.V.	P.I.P.	PEEP/CPAP	CUFF PRESS/VOL PRESS	SPONT. MECHANICS: INSP. FORCE	T.V./V.C.

LAB RESULTS

TIME	INITIALS	FIO_2	pH	PCO_2	PO_2	O_2Sat.	HCO3	BLOOD SUGAR	BUN/CREAT	Na/K	Hct/Hgb

OTHER BLOOD WORK

TIME	XRAY	TIME	EKG

TIME	MEDICATION	TIME	MEDICATION	TIME	MEDICATION
8:45	Enoxaparin 30 mg SQ				

NURSING DIAGNOSIS	EXPECTED OUTCOME	INTERVENTION
1. POTENTIAL FOR PAIN	PATIENT WILL VERBALIZE COMFORT	ASSESS PAIN, REPOSITION FOR COMFORT, MEDICATE PRN. REASSESS PAIN.
2. POTENTIAL FOR ALTERATION IN TISSUE PERFUSION	TISSUE PERFUSION WILL BE MAINTAINED	MONITOR VITAL SIGNS FREQ. APPLY WARM BLANKETS. MAINTAIN PATENT AIRWAY. CHECK OPERATIVE SITE FREQUENTLY.

FLUID BALANCE

INTAKE

TIME/ AMT.	FLUID DISC.	R.R. CRYSTALOIDS FLUID TOTALS	ABS	CUM	TIME/ AMT.	FLUID DISC.	R.R. BLOOD PRODUCTS TOTALS	ABS	CUM
	500	LR	500						
		ORAL INTAKE					INTRAVENOUS MEDS		
200 Cranberry									
mSmns									
200 Cranberry			400						

INTRAVENOUS

LINE	LOCATION	INSERTION DATE
1. PERIPHERAL	#20 (L) hand	9/11
2. PERIPHERAL		
3. CVP		
4. PA		
5. ARTERIAL		
SUTURED Y ☐ N ☐		
6. OTHER		

INTRAVENOUS RATE LR ML/HR 100

OUTPUT

OR URINE OUTPUT ______ DTV 2215 OTHER OUTPUT ______

TIME	HRLY	CUM	IRRIGATION TOTAL OUT	IRRIGATION CUM	TIME	TUBES/DRAINS			

DRAINS

- ☐ Jackson/Pratt
- ☐ Hemovac
- ☐ Foley
- ☐ Salem Sump
- ☐ Chest Tube
- ☐ Packing
- ☐ Penrose
- ☐ Pain Pump
- ☐ Other

INTAKE TOTALS

O.R. BLOOD	
O.R. CRYSTALLOID	500
O.R. TOTAL	500
RECOVERY ROOM BLOOD	
RECOVERY ROOM CRYSTALLOID	500
RECOVERY ROOM INTRAVENOUS MEDICATION	400
RECOVERY ROOM ORAL	
RECOVERY ROOM TOTAL	900
TOTAL INTAKE ☐	1400

OUTPUT TOTALS

O.R. EBL	
TOTAL URINE	
RECOVERY ROOM DRAIN	
OTHER	
TOTAL OUTPUT ☐	0

DAY SURGERY DISCHARGE LIST

- DISCHARGE INSTRUCTIONS REVIEWED W/ PATIENT AND RESPONSIBLE ADULT ☑
- PATIENT VERBALIZES UNDERSTANDING ☑
- COPY OF INSTRUCTIONS & SCRIPT (IF APPLICABLE) GIVEN ☐ /
- PATIENT TRANSFERRED TO CAR VIA WC ☑ AMB ☐
- PATIENT PLACED IN CARE OF RESPONSIBLE ADULT ☑
- PAIN SCALE ON DISCHARGE (0-10) 2
- QUALITY OF PAIN: D))

D = DULL, B = BURNING, P = PRESSURE, S = SHARP, T = THROBBING, O = OTHER

TRANSFER CHECK LIST

- TIME
- REPORT GIVEN TO:
- PATIENT TRANSFERRED TO:
- VIA STRETCHER ☐ BED ☐ W/C ☐
- PATIENT ESCORTED BY STAFF ☐
- BED ↓ ☐ SIDERAILS X2 ↑ ☐
- CALL LIGHT GIVEN TO PATIENT W/INSTRUCTIONS ☐
- PAIN SCALE ON TRANSFER (0-10)
- QUALITY OF PAIN:

D = DULL, B = BURNING, P = PRESSURE, S = SHARP, T = THROBBING, O = OTHER

PROGRESS NOTES

TIME		TIME	
1411	PATIENT ARRIVED IN PHASE I ☑ PHASE II ☐		
	PER STRETCHER ☑ CHAIR ☐ BED ☐		
	POSITION SUPINE ☑ LEFT SIDE ☐ RIGHT SIDE ☐ SITTING ☐		
	HOB ELEVATED ☑ FLAT ☐		
	ID BAND ☑ PATIENT ID VERIFIED ON ADMIT ☑		
	ALARM DEFAULT PARAMETERS ON YES ☑ NO ☐		
	Pt. admitted to pacu. Arouses		
	c̄ verbal stimulation.		
	(R) knee dsg D+I. ↑ on pillow		
	Ice on. Palpable pedal pulse		
	foot warm. Good CSM		
	VSS. Warm blanket on. JN		
1500	Continues to deny pain.		
	VSS. Dsg D+I. JN		
1515	Transitioned to Recliner		
	s̄ incident. Snack given.		
	Report to S. Rahard(?)		
	to phase 2. JN		
1521	Pt accepted to P2 snack &		
	drink given		
	Family contacted to come &		
	sit c̄ pt. Security in to give pt		
	belongings back		
	Instructions given to pt [illegible]		
1545	Dad in — instructions [illegible]		
	& script given. [illegible] given		
	IV removed c pt dressing		
	VAd		
	pt Add		

Signature / Title	Initial
June Nicholas RN	JN
[signature]	S

POST-ANESTHESIA DISCHARGE NOTE

SATISFACTORY RECOVERY FROM ANESTHESIA ☐ YES ☐ NO

IF NO, COMMENT ON PROGRESS NOTES ______________ MD ______ ______

SIGNATURE DATE TIME

Faulkner Hospital
1153 Centre Street
Boston, MA 02130

Patient Name:ROLLINS,JAMES
Medical Record #:01018512
Provider Name:BLEY,LOUIS M.D.
Admission Date:09/11/08
Discharge Date:
Report No:9586309

OPERATIVE NOTE

DATE OF SURGERY:
09/11/08.

SURGEON:
Louis Bley, MD.

ASSISTANT:

PREOPERATIVE DIAGNOSIS:
Right knee medial meniscal tear.

POSTOPERATIVE DIAGNOSIS:
Right knee medial meniscal tear, plus grade II-III chondrosis medial joint compartment, grade III-IV chondrosis femoral trochlea.

OPERATION:
Right knee arthroscopy, partial medial meniscectomy and abrasion chondroplasty femoral trochlea.

ANESTHESIA:
General endotracheal.

ESTIMATED BLOOD LOSS:
Minimal.

DISPOSITION:
To recovery room alert and oriented.

INDICATIONS:
The patient is a very pleasant 52-year-old male with mechanical symptoms in the right knee, unrelieved by conservative treatment. He also had underlying osteoarthritic symptoms of stiffness and start-up discomfort. A preoperative MRI revealed a medial meniscal tear. In light of this, the risks and benefits of arthroscopic surgery were explained to the patient including the fact that the surgery would not address his underlying stiffness and start-up discomfort. After extensive discussions, he elected to proceed with operative care.

DESCRIPTION OF PROCEDURE:
After informed consent was obtained, the patient was taken to the operating room on 09/11/08. He was placed supine on the operating table and induced under general anesthesia. His right lower extremity was prepped and draped in the usual sterile fashion for a right knee arthroscopy.

The medial and lateral portal sites were injected with 1% Xylocaine

Run: 10/30/08-16:35 by BLEY,LOUIS M.D.

Faulkner Hospital
1153 Centre Street
Boston, MA 02130

Patient Name:ROLLINS,JAMES
Medical Record #:01018512
Provider Name:BLEY,LOUIS M.D.
Admission Date:09/11/08
Discharge Date:
Report No:9586309

OPERATIVE NOTE

with epinephrine 1:100,000. Following this, the arthroscope was bluntly inserted through a standard lateral arthroscopic portal and systematic examination was undertaken. Immediately, the patellofemoral joint was found to have diffuse grade II-III chondrosis within a linear portion of the femoral trochlea. The medial compartment was entered and a posterior medial meniscal tear was identified. A medial working portal was created under direct visualization and small upbiting-type instruments and a 3.5 incisor were used to debride the meniscus back to a stable margin. The intercondylar notch was found to be intact. The ACL and PCL were intact. The lateral compartment had some diffuse grade I-II chondrosis but had no evidence of meniscal pathology.

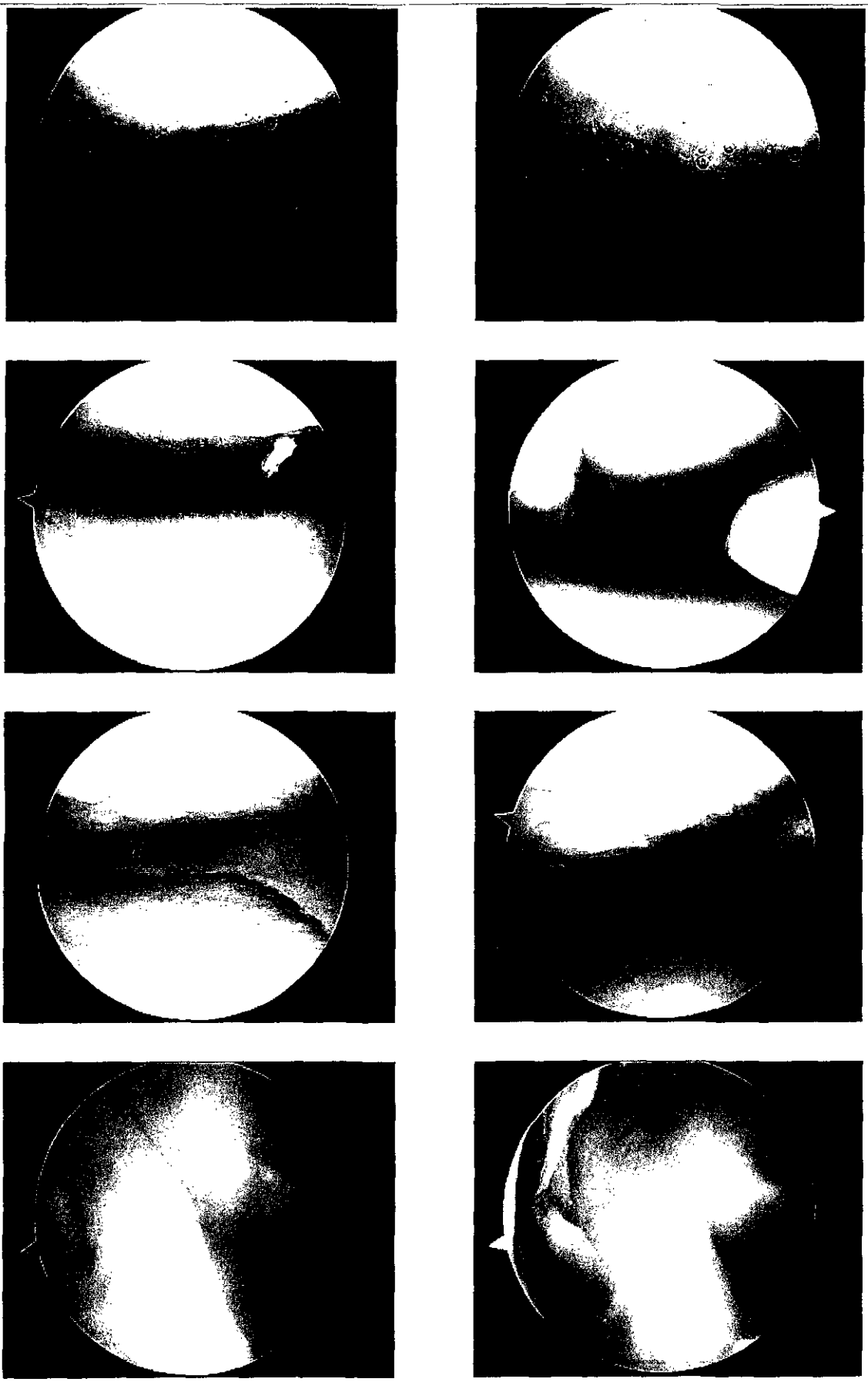
Attention was turned back toward the intercondylar notch. Using a 4.5 incisor an abrasion chondroplasty was performed and a small area of central grade IV chondrosis within the femoral trochlea. Following this, the knee was copiously irrigated with normal saline through the arthroscopic pump. It was exsanguinated to assure bleeding within the abrasion chondroplasty bed. Following this, 30 mL of 0.25% Marcaine was injected via the arthroscopic cannula which was removed. The skin portals were closed with simple 3-0 nylon sutures. A bulky soft dressing was applied. The patient was then awakened, extubated and transported to the recovery room alert and oriented. There were no complications.

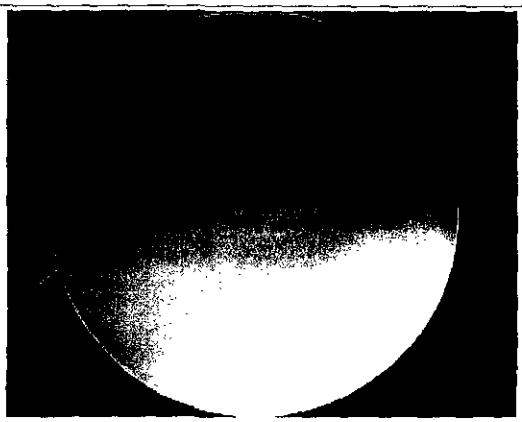
[Dictation ID#9586309]

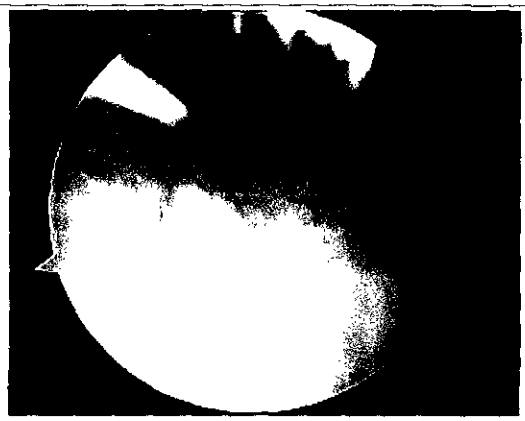
Signature On File 10/30/08 BLEY,LOUIS M.D.

Date of Dictation 09/11/08
Date of Transcription 09/12/08

Run: 10/30/08-16:35 by BLEY,LOUIS M.D.







SRS
SPECIALTY RISK SERVICES

May 1, 2008

Gilbert R. Hoy Jr., Esquire
15 North Beacon Street
Allston MA 02134

RE: Account: Circuit City Stores Inc
Claimant: James Rollins
Date of Loss: 1/28/2008
Claim Number: YLB49189L

Dear Mr. Hoy,

We have carefully considered your client's claim. Based upon the information obtained to date, it is our opinion that our account would not be held responsible for this accident. The following is the reason behind our denial:

The end cap is used to display merchandise and it is very visible. Our investigation has failed to show that this end cap was dangerous or hazardous, and there was more than sufficient space for your client to walk past the end cap. Your client was not watching where he was walking when he walked into and tripped over the end cap. Therefore, we must respectfully decline payment of your client's claim.

If you have any questions, feel free to contact me at the number below.

Sincerely,

Lisa Griffith
Account Consultant
PO Box 799
Marlton NJ 08053-0799
Direct Dial: (856) 355-4482
Toll Free: (800) 630-0746 x54482
Facsimile: (866) 913-4535

KLG

KECHES | LAW | GROUP
A PROFESSIONAL CORPORATION

122 Dean Street
Taunton, MA 02780

508-822-2000 Taunton
617-426-7900 Boston
508-822-8022 Fax

www.kecheslaw.com

March 3, 2010

email: cglinka@kecheslaw.com

VIA CERTIFIED MAIL
RETURN RECEIPT REQUESTED

Circuit City Stores, Inc., et al. Claims Processing
c/o Kurtzman Carson Consultants LLC
2335 Alaska Avenue
El Segundo, CA 90245

RE: Proof of Claim form
Claimant: James L. Rollins
Case No. 08-35653-KRH

Dear Sir or Madam:

Please be advised that I represent Mr. Rollins relative to personal injuries he sustained on or about January 28, 2008, at the Circuit City Store located in Dorchester, Massachusetts.

As instructed by the Eastern District of Virginia Bankruptcy Court (Richmond Division), I enclose herewith my client's Proof of Claim form.

Please direct any future correspondence in this matter to my attention.

Thank you for your courtesy in this regard.

Very truly yours,

KECHES LAW GROUP, P.C.

Charlotte E. Glinka

CEG/dkd
Enclosure
VABC1-FilingPOC

RRR #: 7008 1830 0000 9332 2332

B 10 (Official Form 10) (12/08)

UNITED STATES BANKRUPTCY COURT Eastern District of Virginia	PROOF OF CLAIM
Name of Debtor: Circuit City Stores, Inc.	Case Number: 08-35653-KRH

NOTE: *This form should not be used to make a claim for an administrative expense arising after the commencement of the case. A request for payment of an administrative expense may be filed pursuant to 11 U.S.C. § 503.*

Name of Creditor (the person or other entity to whom the debtor owes money or property):
James L. Rollins

☐ Check this box to indicate that this claim amends a previously filed claim.

Name and address where notices should be sent:
Charlotte E. Glinka, Esq.
Keches Law Group, P.C.
122 Dean Street
Taunton, MA 02780
Telephone number:
(508) 822-2000

Court Claim Number: _____ (*If known*)

Filed on: _____

Name and address where payment should be sent (if different from above):

Telephone number:

☐ Check this box if you are aware that anyone else has filed a proof of claim relating to your claim. Attach copy of statement giving particulars.

☐ Check this box if you are the debtor or trustee in this case.

1. Amount of Claim as of Date Case Filed: $ 150,000.00

If all or part of your claim is secured, complete item 4 below; however, if all of your claim is unsecured, do not complete item 4.

If all or part of your claim is entitled to priority, complete item 5.

☐ Check this box if claim includes interest or other charges in addition to the principal amount of claim. Attach itemized statement of interest or charges.

2. Basis for Claim: Personal Injury
(See instruction #2 on reverse side.)

3. Last four digits of any number by which creditor identifies debtor: _____

3a. Debtor may have scheduled account as: _____
(See instruction #3a on reverse side.)

4. Secured Claim (See instruction #4 on reverse side.)
Check the appropriate box if your claim is secured by a lien on property or a right of setoff and provide the requested information.

Nature of property or right of setoff: ☐ Real Estate ☐ Motor Vehicle ☐ Other
Describe:

Value of Property:$_____ **Annual Interest Rate**___**%**

Amount of arrearage and other charges as of time case filed included in secured claim, if any: $_____ **Basis for perfection:** _____

Amount of Secured Claim: $_____ **Amount Unsecured: $**_____

5. Amount of Claim Entitled to Priority under 11 U.S.C. §507(a). If any portion of your claim falls in one of the following categories, check the box and state the amount.

Specify the priority of the claim.

☐ Domestic support obligations under 11 U.S.C. §507(a)(1)(A) or (a)(1)(B).

☐ Wages, salaries, or commissions (up to $10,950*) earned within 180 days before filing of the bankruptcy petition or cessation of the debtor's business, whichever is earlier – 11 U.S.C. §507 (a)(4).

☐ Contributions to an employee benefit plan – 11 U.S.C. §507 (a)(5).

☐ Up to $2,425* of deposits toward purchase, lease, or rental of property or services for personal, family, or household use – 11 U.S.C. §507 (a)(7)

☐ Taxes or penalties owed to governmental units – 11 U.S.C. §507 (a)(8).

☐ Other – Specify applicable paragraph of 11 U.S.C. §507 (a)(___).

Amount entitled to priority:

$_____

**Amounts are subject to adjustment on 4/1/10 and every 3 years thereafter with respect to cases commenced on or after the date of adjustment.*

6. Credits: *The amount of all payments on this claim has been credited for the purpose of making this proof of claim.*

7. Documents: Attach redacted copies of any documents that support the claim, such as promissory notes, purchase orders, invoices, itemized statements of running accounts, contracts, judgments, mortgages, and security agreements. You may also attach a summary. Attach redacted copies of documents providing evidence of perfection of a security interest. You may also attach a summary. *(See instruction 7 and definition of "redacted" on reverse side.)*

DO NOT SEND ORIGINAL DOCUMENTS. ATTACHED DOCUMENTS MAY BE DESTROYED AFTER SCANNING.

If the documents are not available, please explain:

Date: 03/02/10

Signature: The person filing this claim must sign it. Sign and print name and title, if any, of the creditor or other person authorized to file this claim and state address and telephone number if different from the notice address above. Attach copy of power of attorney, if any.

James L Rollins

James L. Rollins

FOR COURT USE ONLY

Penalty for presenting fraudulent claim: Fine of up to $500,000 or imprisonment for up to 5 years, or both. 18 U.S.C. §§ 152 and 3571.

Circuit City Stores, Claims Processing
c/o Kurtzman Carson Consultants LLC
2335 Alaska Ave
El Segundo, CA 90245

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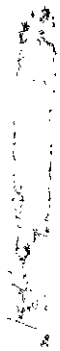
James L Rollins
Charlotte E Glinka Esq
Keches Law Group PC
122 Dean St
Tarunton, MA 02780

PROOF OF CLAIM CONFIRMATION
Your proof of claim filed against **Circuit City Stores, Inc.,**
case no **08-35653** was received on **3/8/2010**
and assigned claim number **14825**

For more information, please visit **www.kccllc.net/circuitcity** or call 1-866-381-9100

027803827B3 C003



KLG

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July 14, 2010

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VIA FEDERAL EXPRESS

Clerk of the Bankruptcy Court
United States Bankruptcy Court
701 East Broad Street - Room 4000
Richmond, Virginia 23219

Re: In re: Circuit City Stores, Inc., et al.,
Case No.: 08-35653-KRH (Chapter 11)

Dear Madam or Sir:

In reference to the above matter, enclosed please find:

1. *Claimant James Rollins' Response to Debtors' Seventy-ninth Omnibus Objection to Claims (Disallowance of Certain Legal Claims); and*
2. Certificate of Service.

Thank you.

Very truly yours,

KECHES LAW GROUP, P.C.

Charlotte E. Glinka

Charlotte E. Glinka ckd

Enclosures
VABC2-Response

cc: VIA FEDERAL EXPRESS
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